

**WISCONSIN MEDICAID  
RECORD OF ACTUAL DAILY OXYGEN USE**

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services. The use of this form is voluntary, and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

**INSTRUCTIONS:** Attach this completed form to the Prior Authorization/Oxygen Attachment (PA/OA), HCF 11066, when submitting PA requests for recipients residing in a nursing facility. In Section III, place an "X" in each shift for each day that the recipient actually received oxygen. The recipient must receive oxygen for at least 15 days of a 30-day rental period for a PA request to be considered for approval. The oxygen need not be administered for the whole shift. Leave blank any shifts when oxygen was not administered. Providers may submit a completed copy of this form or a copy of the nursing home's oxygen use records with paper or faxed PA requests. Information on this form must match the recipient's medical records exactly. A new form should be completed for each new PA request for oxygen-related services.

**SECTION I — PROVIDER INFORMATION**

|                              |   |
|------------------------------|---|
| Name — Prescribing Physician | Prescribing Physician's Medicaid Provider No. or Universal Provider Identification Number |
|------------------------------|---|

**SECTION II — RECIPIENT INFORMATION**

|  |  |
|--|--|
| Name — Recipient (Last, First, Middle Initial) | Recipient Medicaid Identification Number |
|--|--|

**SECTION III — RECORD OF DAILY USE**

Complete the date oxygen was initiated in MM/DD/CCYY format. This date is "Day 1." \_\_\_\_ / \_\_\_\_ / \_\_\_\_

|     | DAY 1  | DAY 2  | DAY 3  | DAY 4  | DAY 5  | DAY 6  | DAY 7  |
|-----|--------|--------|--------|--------|--------|--------|--------|
| AM  |        |        |        |        |        |        |        |
| PM  |        |        |        |        |        |        |        |
| NOC |        |        |        |        |        |        |        |
|     | DAY 8  | DAY 9  | DAY 10 | DAY 11 | DAY 12 | DAY 13 | DAY 14 |
| AM  |        |        |        |        |        |        |        |
| PM  |        |        |        |        |        |        |        |
| NOC |        |        |        |        |        |        |        |
|     | DAY 15 | DAY 16 | DAY 17 | DAY 18 | DAY 19 | DAY 20 | DAY 21 |
| AM  |        |        |        |        |        |        |        |
| PM  |        |        |        |        |        |        |        |
| NOC |        |        |        |        |        |        |        |
|     | DAY 22 | DAY 23 | DAY 24 | DAY 25 | DAY 26 | DAY 27 | DAY 28 |
| AM  |        |        |        |        |        |        |        |
| PM  |        |        |        |        |        |        |        |
| NOC |        |        |        |        |        |        |        |
|     | DAY 29 | DAY 30 | DAY 31 |        |        |        |        |
| AM  |        |        |        |        |        |        |        |
| PM  |        |        |        |        |        |        |        |
| NOC |        |        |        |        |        |        |        |